



**Flexible Spending Accounts
for
Kentucky State Government Employees**

Administered by

**Personnel Cabinet
Office of Public Employee Health Insurance
(OPEHI)**

Plan Year 2002

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Flexible Spending Accounts

WHAT IS A FLEXIBLE SPENDING ACCOUNT?



The Commonwealth Choice Flexible Spending Accounts provide you a way to pay for eligible uninsured Health Care expenses and Dependent Day Care expenses with TAX FREE money. By directing “pre-tax” money from your paycheck into one or both of these accounts, **you can put up to 41% of the money you are spending on eligible expenses back into your pocket.** (i.e., If you contribute \$10.00 a pay period, you will save up to \$4.10 on every \$10.00 contributed. Therefore your tax free savings for one month could = \$8.20, and the yearly savings could total \$98.40).

I HEARD THAT MY EMPLOYER MIGHT PUT MONEY INTO ONE OF THESE ACCOUNTS FOR ME?

YES! You may be eligible for an Employer Contribution towards the **Health Care Spending Account** if the monthly cost of the health insurance plan you choose is less than \$234.00. **Note: The Dependent Day Care Account is not eligible for an employer contribution.**

HOW DO I KNOW IF I QUALIFY FOR THE EMPLOYER CONTRIBUTION?

Use the worksheet on the back cover to determine if you qualify. The following three (3) requirements must also be met:

1. You must be an active Kentucky State Government employee who is eligible for state-sponsored health insurance coverage.

2. Your health plan must total less than \$234.00 per month **or** you may waive coverage and deposit up to \$2,808.00 of state contributions into your account for the year.

Note: If you elect to waive your health insurance, you must fill out sections I and V of the health insurance application. You must complete both the health insurance application and the Commonwealth Choice application and turn them in to your insurance coordinator.

3. You **must elect to participate** in the Flexible Spending Account Program **by completing the enrollment form** found in this booklet. Enrollment is NOT automatic. Your participation will **not “roll over” from one year to the next.** If you wish to participate, complete your enrollment form now.

HOW MUCH WILL MY EMPLOYER CONTRIBUTE?

The amount of contribution depends on the cost of the health plan you choose. Let's use an example:

The employer contribution for health insurance for the 2002 plan year is:	\$234.00
You choose a plan with a monthly cost of:	\$232.40
The monthly employer contribution to your Health Care Account:	\$1.60
(or \$.80 per paycheck)	

REMINDER: The minimum combined (employer and employee) contribution to a Health Flexible Spending Account is **\$5.00 per paycheck.** You would have to deposit \$8.40 per month or \$4.20 per paycheck of your own money to meet the \$5.00 minimum contribution.

Using the figures in the previous example, \$19.20 a year would be deposited into your Health Care account by your employer.

WHAT IF I DON'T QUALIFY FOR AN EMPLOYER CONTRIBUTION?

You may also choose to direct money from your own paycheck into the account. This means you can save as much as 41 cents on every dollar you spend on health care expenses that are not covered by your insurance. Remember, contributions are tax-free. **(Maximum combined contribution, employer and employee, is \$120.00 per paycheck).**

HOW CAN THE MONEY IN THIS ACCOUNT BE USED?

The money in your Health Care Spending Account can be used to reimburse you for **uninsured medical expenses incurred by you, your spouse or dependent children.** To be considered a dependent child(ren), the person must live with you as a member of your household and you must have provided over one half of his/her total support for the calendar year. The dependent child or spouse does not have to be carried on your insurance. Your spouse and/or dependent child also does not have to be claimed as a dependent for tax purposes.

Reimbursable items include deductibles, co-payments, eye care, glasses/contact lenses, dental fees, orthodontic work, etc. See page 6 of this book for a more detailed list.

IS THERE A FEE FOR USING THIS PROGRAM?

No. The plan is made available to you, **free of charge**, as a benefit to employees.

HOW DO THE SPENDING ACCOUNTS WORK?

First, you establish a Health Care Spending Account, a Dependent Day Care Spending Account, or both, if you have both types of expenses. You do this by completing an enrollment form during the annual Open Enrollment period. ***Make sure you return the form to your Agency Insurance Coordinator before the deadline, which is September 28, 2001.***



The amount you designate on your enrollment form as the "participant contribution" will be deducted from your salary each pay period **before taxes are calculated**, and deposited into your account. This makes your contributions **TAX-FREE.**

WHO MAY PARTICIPATE IN COMMONWEALTH CHOICE?

If you are an active Kentucky State Government employee who is eligible for state-sponsored health insurance coverage,



you may enroll in one or both of the Flexible Spending Accounts during the Open Enrollment period. The plan year begins January 1, 2002.

New employees, who are eligible for state-sponsored health insurance coverage, may enroll in the Commonwealth Choice program within **30 days** of their date of hire. Benefits will begin on the first day of the second month following their date of hire. The number of regular pay periods on the form will be adjusted to reflect the actual number of pay periods remaining in the plan year.

HOW DO I GET REIMBURSED FOR MY ELIGIBLE EXPENSES?

It's simple. Once an eligible expense has been incurred, complete a reimbursement form, attach your paid receipt, itemized statement, or explanation of benefits from



your health insurance plan, and mail it to Commonwealth Choice Reimbursement, P. O. Box 5035, Greenville, SC 29606-5035 (your agency coordinator will have a supply of reimbursement forms). Best of all, you never owe taxes on the money you use to reimburse yourself.

NOTE: A minimum of \$25.00 in reimbursable expenses is required before a check will be issued. Hunt, Dupree and Rhine will hold smaller amounts until you have accumulated the \$25.00 minimum in expenses or at the end of each quarter.

RULES FOR FLEXIBLE SPENDING ACCOUNTS

The following rules apply to both Health Care Spending Accounts and Dependent Day Care Spending Accounts:

1. Eligible expenses must be incurred in the same plan year that your contributions are made. Such expenses have to have been paid before submitting them for reimbursement. You cannot be reimbursed for the portion of expenses for which your health insurance is responsible. A claim can only be paid for you **one time**, whether it is by your health insurance carrier or by reimbursement through your Health Care Spending Account.
2. You may not claim reimbursed expenses for income tax deduction purposes.
3. You have a **90-day grace period** at the end of the plan year to request reimbursement of eligible expenses that you have had during the plan year. That means you may request reimbursement of eligible expenses until **March 31** following the end of the plan year. HOWEVER, the expense must have been incurred in the

previous plan year. If you terminate employment during the plan year, you have 90 days from that date to request reimbursement of eligible expenses.

WHEN MAY I FILE FOR REIMBURSEMENT?

You may file for reimbursement at the time you receive and pay for the service. However, unless the reimbursement is at least \$25.00, you will not receive a check until you have accumulated a minimum of \$25.00 in reimbursable costs or at the end of a quarter.

- Dependent Day Care expenses will only be reimbursed up to the deposited amount available in your account at the time you file.
- The total amount for eligible Health Care expenses is available from the beginning of the plan year, up to the amount of your annual contribution, less any reimbursements already paid.

WHAT HAPPENS IF I LEAVE MONEY IN MY ACCOUNT AT THE END OF THE PLAN YEAR?

IRS regulations stipulate that any money left in your account after all reimbursements have been processed may not be returned to you or carried forward to the next plan year. This is known as the **“Use It or Lose It”** rule. HOWEVER, the tax savings of this program are so great that even if you leave a small balance in your account, the amount you save in taxes will most likely be greater than any amount forfeited. *The key is to be conservative when estimating your eligible expenses for the year.*

HEALTH CARE SPENDING ACCOUNT

HOW DO I KNOW IF I WILL BENEFIT FROM THIS ACCOUNT?

If you and your family members have predictable, out-of-pocket medical, dental, and/or vision expenses, this account will benefit you. The actual dollar amount you will save depends on your tax bracket.

SHOULD I USE THE HEALTH CARE ACCOUNT OR THE IRS DEDUCTION?



By using the Health Care Spending Account you are 100% reimbursed for predictable out-of-pocket expenses. The IRS Tax Deduction is only for those medical expenses that exceed 7.5% of your adjusted gross income and you

are required to itemize those expenses. Also, by using the Health Care Account you save tax dollars throughout the year.

IS THERE A MINIMUM AND MAXIMUM CONTRIBUTION?

YES. The minimum combined contribution (employer and employee) is \$5 per pay period. The maximum combined contribution (employer and employee) is \$120.00 per pay period. See line C of the enrollment form.

ELIGIBLE MEDICAL EXPENSES INCLUDE:

- Acupuncture
- Alcoholism treatment
- Ambulance service
- Artificial limbs
- Artificial teeth

- Birth control pills
- Braille books & magazines for use by a person with visual impairment
- Car controls for use by a person with a disability
- Chiropractic care
- Co-insurance for health insurance
- Contact lenses*, saline solution, and enzyme cleaner
- Co-Payments
- Crutches, amount paid to buy or rent
- Dental fees, includes X-rays, fillings, braces, extractions, dentures, etc.
- Deductibles for health insurance
- Dental implants
- Diagnostic tests
- Doctors' fees
- Duplicate prosthetic devices
- Drug addiction treatment at a therapeutic center for drug addiction
- Experimental medical treatment
- Eyeglasses and eye examinations
- Guide dogs/trained animals used to assist persons with a physical disability
- Hearing aids, batteries to operate them, and hearing exams
- Hospital services
- Injections
- In-patient therapy for mental or nervous disorders
- In vitro fertilization
- Lab fees that are part of your medical care
- Laser eye surgery (RK, PRK, Lasik)
- Learning disability tuition for a child who has severe learning disabilities
- Nursing services
- Operations
- Optometrist fees
- Orthodontic treatment **
- Orthopedic shoes
- Oxygen
- Periodontal fees
- Prescription drugs ***
- Psychoanalysis
- Psychologist fees
- Radial keratotomy
- Smoking cessation drugs/programs ***
- Special schools for individuals with disabilities
- Sterilization
- Surgery
- TDD phone for individuals who are deaf or hard of hearing
- Therapy
- Transplants

- Transportation for medical care
- Vitamins prescribed by a doctor ***
- Vaccinations
- Wheelchairs
- X-Rays

*Must be medically necessary to alleviate, treat, mitigate or prevent a medical condition.

**Contract or financial agreement required

*** Over-the-counter drugs and vitamins are not eligible for reimbursement even if a doctor prescribes them.

This is a partial list of expenses that are payable tax free with a Health Care Spending Account. IRS publication 502 contains a more complete list. You may contact Hunt Dupree Rhine & Associates for a more detailed list.

Guidelines for Orthodontia Reimbursement



Orthodontics is an ongoing treatment and the IRS prohibits pre-payment of these services.

For orthodontia reimbursement, send a copy of your orthodontia agreement (orthodontic contract) along with your completed form when treatment begins. The orthodontic agreement must state

1. the beginning date of service
2. the approximate length of service
3. total cost of service
4. record fee
5. initial fee (down payment)
6. subsequent monthly fees
7. total insurance coverage (if applicable)

The fee for orthodontic records is eligible for reimbursement on the date the x-rays, photos, and casts are taken. Proper documentation is a statement of services rendered from orthodontists.

The initial fee (down payment) is eligible for reimbursement on the date of the first treatment. Again proper documentation is a statement of services rendered from orthodontists.

Subsequent monthly fees are eligible for reimbursement as monthly orthodontic adjustments occur. Proper documentation is a statement of services rendered, a receipt from orthodontist showing date of payment ("orthodontic" clearly noted on receipt), or a copy of payment stub from orthodontic payment booklet.

Special payment schedules, which do not coincide with dates of service (such as full payment at banding) will be paid in equal installments over the period of service. **REMEMBER:** orthodontia services that are cosmetic are not eligible for reimbursement.

Expenses That May Not Be Reimbursed Include:

(This is not a complete list)

Amount paid by medical plan
Cosmetic procedures/drugs
Diet foods
Ear piercing
Funeral expenses
Hair growth drugs
Health club dues
Health insurance premiums
LAMAZE class fees
Non-prescription drugs
Weight-loss programs (including prescription drugs that are not medically necessary)

HOW DO I DETERMINE THE AMOUNT OF MONEY TO DEPOSIT IN MY HEALTH CARE ACCOUNT?



Calculate carefully the amount you (and your eligible family members) expect to incur from January 1, 2002 - December 31, 2002 for eligible uninsured medical expenses. Use the

chart on page 9 to help you calculate your medical expenses. **If you qualify for an Employer Contribution to your Health Care Account, be sure to subtract the Employer Contribution from your total anticipated expenses to determine your individual contribution for the year.** This amount will be deducted each pay period from your salary before taxes are calculated.

You may **not** submit proof of payment in the form of a cancelled check unless it is accompanied by other required documentation.

MAY I CHANGE THE AMOUNT DURING THE PLAN YEAR?

You may be able to change your current election and make a new election mid-year if you experience an eligible qualifying event. Most qualifying events that allow you to make a change in your Health Insurance may now permit you to make a change in your Health Care Spending Account. Contact your health insurance coordinator or the Office of Public Employee Health Insurance (OPEHI) at 888-581-8834.



WHAT TYPE OF DOCUMENTATION IS REQUIRED FOR REIMBURSEMENT?

To be reimbursed for an eligible expense you must provide:

- A completed reimbursement request form with supporting documentation as listed below:
 - Fully itemized bill(s) (including dates of service, name of claimant, type of service, etc.) from a doctor, dentist, pharmacy or other supplier; or
 - Explanation of benefits (EOB) statement(s) indicating the deductible, co-insurance and amounts not covered by any medical/dental plan(s) under which the employee or any eligible dependents are covered.

Notes

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WORKSHEET FOR ESTIMATING HEALTH CARE EXPENSES

This worksheet is designed to help you determine the amount to be set aside in your Health Care Flexible Spending Account in the coming year. Keep in mind that eligible expenses cannot include those paid by another source (i.e., expenses covered by the medical or dental insurance plan for either you or your spouse) and must be for services provided during the plan year (January through December). By reviewing the past 12 months of expenses, you can have a much better idea of what your estimated expenses would be for 2002.

Eligible Expenses:	Expenses over Last 12 Months	Estimated Expenses For Next Year
Medical coverage	\$ _____	\$ _____
Deductibles	\$ _____	\$ _____
Co-insurance amounts	\$ _____	\$ _____
Copayment amounts	\$ _____	\$ _____
Non-reimbursed medical expenses	\$ _____	\$ _____
Prescription drug copayments	\$ _____	\$ _____
Dental coverage	\$ _____	\$ _____
Deductibles	\$ _____	\$ _____
Copayment amounts	\$ _____	\$ _____
Non-reimbursed dental expenses	\$ _____	\$ _____
Vision Care	\$ _____	\$ _____
Examinations	\$ _____	\$ _____
Eye Glasses and contact lenses, solution, etc.	\$ _____	\$ _____
Contact lens insurance	\$ _____	\$ _____
Hearing aids and fitting charges	\$ _____	\$ _____
Prosthetic and durable medical equipment	\$ _____	\$ _____
Other health care expenses	\$ _____	\$ _____
Total Unreimbursed Expenses	\$ _____	\$ _____

REMEMBER: There is a maximum combined (employer and employee) contribution of \$120 per pay period.

AVAILABILITY OF FUNDS:

The total amount for eligible uninsured medical expenses is available from the beginning of the plan year, up to the amount of the annual contribution for the plan year, less any reimbursements received to date (Health Care Account only).

DEPENDENT DAY CARE SPENDING ACCOUNT

WHAT CRITERIA MUST I MEET TO ENROLL IN THE DAY CARE ACCOUNT?



1. You may enroll in this account if you incur a day care expense so you can work.

2. If you are married, and you incur a day care expense so you can work and your spouse can work or go to school full time, you may enroll in this account.

3. If you incur an expense so you can work full time and your spouse is incapable of self-care, you are eligible for this account.

NOTE: Employees will be allowed to enroll in the Day Care Account within 30 days of the birth or adoption of a child. Contact your Insurance Coordinator for the proper forms. If you currently do not have children, you do not qualify, BUT you would be eligible when a birth or adoption occurs.

MUST I SEND MY CHILD TO A DAY CARE FACILITY?

NO. The care may be provided either in your home or outside your home by an individual (example: grandparent, aunt, neighbor, etc.) or by a licensed facility. The individual should report this as income. However, neither you, your spouse nor another dependent may provide the care.

WHAT EXPENSES ARE COVERED BY OR THROUGH THIS ACCOUNT?

The account covers:

- ➔ The day care or after school care expenses of a Dependent Child under age 13, or
- ➔ The day care of a Dependent Child or Adult incapable of self-care, or
- ➔ Pre-school, or
- ➔ Summer Day Camps under age 13.

The Account does **NOT** cover the cost of Kindergarten or overnight Summer Camp.

MINIMUM CONTRIBUTION

The minimum contribution is \$5 per pay period.

MAXIMUM CONTRIBUTION

The maximum, in most cases, is \$208 per pay period. However, the following rules may be applicable to you:

1. If you are married but you and your spouse file separate income tax returns, your maximum contribution is \$104 per pay period.
2. If you or your spouse earn less than \$4,992 a year, your maximum contribution is equal to the lower of the two incomes.
3. If your spouse is a full-time student or incapable of self-care, your maximum contribution is \$104 per pay period for one dependent and \$208 per pay period for two or more dependents. Total contribution per family is \$208.00 per pay period.

A line drawing of a hand holding a coin, poised to drop it into a slot. Below the slot is a rectangular box with the word "TAX" written in bold, capital letters.

gross family income to be less than \$24,000 and you are in the 15% tax bracket, the IRS tax credit may be the best choice for you. If you are not in the 15% bracket or you expect your adjusted gross family income to exceed \$24,000, the Dependent Day Care Spending Account will probably benefit you more.



**COMMONWEALTH
CHOICE**

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The chart below will help you determine whether the tax credit or the Dependent Day Care Spending Account will benefit you more.

How to use the Chart. . .

1. Find your income in the left-hand column.
2. Determine your filing status: married, joint return, or head of household.
3. Follow the top heading across to find your number of dependents and your annual estimated dependent care expenses.

“T” means the IRS tax credit may benefit you more;

“R” means reimbursements through the Spending Account may benefit you more.

	1 Dependent		2 Dependents			
Estimated Annual Day Care Expenses	\$1,200	\$2,400	\$1,200	\$2,400	\$3,600	\$4,800
\$18,000 Annual Family Adjusted Gross Income						
• Married, File Joint Return	T	T	T	T	T	T
• Head of Household	T	T	T	T	T	T
\$22,500 Annual Family Adjusted Gross Income						
• Married, File Joint Return	T	T	T	T	T	T
• Head of Household	T	T	T	T	T	T
\$24,000 Annual Family Adjusted Gross Income						
• Married, File Joint Return	R	R	R	R	R	R
• Head of Household	R	R	R	R	R	R
\$28,000 Annual Family Adjusted Gross Income						
• Married, File Joint Return	R	R	R	R	R	R
• Head of Household	R	R	R	R	R	R
\$32,000 Annual Family Adjusted Gross Income						
• Married, File Joint Return	R	R	R	R	R	R
• Head of Household	R	R	R	R	R	R

WHAT WILL I NEED TO REQUEST REIMBURSEMENT FOR DAY CARE EXPENSES?

Your reimbursement request for Day Care Expenses must include the name, address, and tax identification number of the facility or the Social Security Number and signature of the individual providing the Dependent Day Care service. **Reimbursement(s) will be made for NO more than the Account balance at the time claim(s) is submitted.**

GENERAL QUESTIONS ABOUT SPENDING ACCOUNTS

MAY I CHANGE THE AMOUNT OF MY CONTRIBUTION DURING THE YEAR?

The IRS requires your enrollment in Commonwealth Choice to continue for the entire plan year, which is January 1 through December 31. However, you can modify your contributions to the **Dependent Day Care Spending Account** if you experience a valid Family Status Change: e.g., marriage; divorce; dependent's birth, death, adoption, or ineligibility; spouse's change in employment; employee's termination of employment, unpaid leave of absence or other related change.

If you experience a Family Status Change, you **MUST** complete a Family Status Change Form and return it – along with documentation to your Insurance Coordinator **within 30 days** of the change. The Personnel Cabinet will review your Family Status Change.

IMPORTANT: Mid-year election changes may be made to the Health Care Spending account for most qualifying events that allow you to make a change in your Health Insurance. If you experience one of these events, you may be allowed to make a change in the amount of contribution (employer and/or participant) to your account.

WHAT HAPPENS TO MY ACCOUNT IF I TERMINATE EMPLOYMENT, RETIRE, OR GO ON LEAVE WITHOUT PAY?

Any employee participating in the **Health Care Spending Account** who terminates from his/her job, retires, or reduces his/her hours of work (such as going on leave

without pay [LWOP]), will be given the opportunity to continue participation for 18 months in the program under COBRA. It is not necessary to continue your health insurance under COBRA in order to continue participation in the Health Care Spending Account under COBRA.

If you do not elect COBRA under the Health Care Spending Account, you will only be eligible for reimbursement of expenses you incurred in the current plan year prior to your termination, retirement, or reduction in hours worked. **You will be given a 90 day grace period to file for reimbursement of expenses you incurred while you were actively employed.** If you return to work within the same plan year, you will not be allowed to rejoin the program unless you elected COBRA.

DOES COMMONWEALTH CHOICE AFFECT MY RETIREMENT BENEFITS?

Your contributions to Commonwealth Choice do not reduce your future Retirement System benefits. Any salary directed to your Commonwealth Choice is included in the compensation reported to the Kentucky Retirement Systems.

WHAT ABOUT MY DEFERRED COMPENSATION?

Participation in a Commonwealth Choice Flexible Spending Account may affect an employee's maximum contribution to the Kentucky Public Employee's 457 Deferred Compensation Plan (Plan I). Commonwealth Choice reduces the gross income from which the maximum deferrable amount is computed. Therefore, flexible benefit plan contributions should be reviewed carefully

by employees who are now contributing the allowable maximum to the 457 deferred compensation plan. The Kentucky Public Employees' 401(k) Deferred Compensation Plan (Plan II) is not impacted by a Commonwealth Choice Flexible Spending Account.

The 2002 maximum allowable contribution for an employee contributing to Deferred Compensation Plan I (Internal Revenue Code, Section 457) is \$11,000 or 100% of adjusted gross income whichever is less. Adjusted gross is income remaining after reduction of employer "pick-up" of retirement contribution, health insurance premiums, flexible spending accounts, shelter plans, e.g., 457's, 401(k)'s, 403(b)'s.

There are anticipated changes that will be effective 01/01/02 so please call Deferred Comp at 1-800-542-2667 or (502) 573-7925 if you have any questions and to ensure you are within the allowable maximum under the Internal Revenue code guidelines.

WILL MY SOCIAL SECURITY BENEFITS BE AFFECTED?

Social Security is a tax assessed against your gross income up to a cap. If your salary for one year reaches the cap, you have paid the maximum amount of Social Security tax the law requires. Therefore, your Commonwealth Choice participation will not reduce the amount of your Social Security benefit available to you at retirement. However, if your salary is below the cap, you are reducing the amount of taxes you pay and your Social Security will be reduced at retirement time.

WHAT ABOUT HEALTH INSURANCE?

Participation in the tax-free Commonwealth Choice program does not change your health benefit coverage in any way.

COMMONWEALTH CHOICE AND THE IRS

Commonwealth Choice is tax free and allowed by the IRS. The portion of your salary set aside for Spending Accounts through Commonwealth Choice will not be included in the taxable salary reported to the IRS on your W-2 form. However, your annualized dependent care contributions will appear on your W-2 for informational purposes only. You will not have to claim these payments as income at the end of the year. **NOTE: Your Commonwealth Choice deductions cannot be used as itemized deductions for income tax purposes at the end of the year.**

If you have a Day Care Account you must complete IRS Form #2441 & submit with your tax return at the end of the year.

All employees who enroll during Open Enrollment will receive a confirmation letter from Hunt, Dupree & Rhine by January 31, 2002. If you completed a form and do not receive your letter, you **MUST** contact the Personnel Cabinet – OPEHI toll free (1-888-581-8834) or (502) 564-6534 (Frankfort) by March 1, 2002, or you are **NOT ENROLLED**.

DETAILED QUESTIONS ON CLAIMS & BALANCES

HUNT, DUPREE, RHINE & ASSOCIATES

1-800-403-2839

Automated # 1-800-413-6706

GENERAL INFORMATION - PERSONNEL CABINET - OPEHI

1-888-581-8834

1-502-564-6534

You must complete the enrollment form found in this booklet in order to participate in the Spending Account program for the 2002 plan year.

**Your enrollment during 2001 will not roll over to 2002.
YOU MUST RE-ENROLL**

Whether you qualify for the Employer Contribution, or you want to contribute your own money, you **MUST** complete the enrollment form in order to participate. Enrollment in the Commonwealth Choice Flexible Spending Account program is **NOT AUTOMATIC**. Employees who are participating in 2001 must re-enroll in order to participate for 2002.

COMPLETING THE ENROLLMENT FORM
**IN ALL CAPITAL LETTERS USE A BLUE OR BLACK PEN ONLY AND PRESS FIRMLY
SO THE INFORMATION CAN BE READ ON ALL THREE COPIES.**

- If enrolling during Open Enrollment **fill in Open Enrollment Circle.**
- If enrolling as New Employee **fill in New Employee Circle.**
 - A new Employee must include the date he/she was hired.

1. In the top Section **PRINT** inside the boxes using **ALL CAPITAL LETTERS**. On the first line insert First Name, Middle Initial and Social Security Number. On the second line insert Last Name. Lines 3-5 are for your Address. On line six insert Daytime Phone. Please write name of State Agency where you are employed on line provided.
2. Determine if you are eligible for an Employer Contribution to the Health Care Account by using the worksheet on the back cover of this booklet. If the amount of your health plan selected (line "2") is less than \$234.00 (line "1"), you qualify for an Employer Contribution to the Health Care Account. **Attention: The MAXIMUM CONTRIBUTION per pay period to the Health Care Account is \$120.00!**

You must divide line "3" in half. This amount will be deposited into your account every pay period or 24 times during the year (unless you are a new employee). This figure goes on line "A" in the Health Care Account side of the application. If this figure can not be divided by 2 evenly, you **MUST ROUND DOWN**. (Minimum combined contribution is \$5.00).

If line 2 is more than line 1 (\$234.00), enter -0- on line 3. You **are not** eligible for an Employer Contribution. However, you may contribute your own "Tax-Free" money by indicating a dollar amount on line B. (\$5.00 minimum)

3. If you are enrolling in the Dependent Day Care Account, you **MUST** mark the appropriate box under "TAX FILING STATUS". Enter the amount you want deposited into the Day Care Account. Contributions will be deducted from your paycheck on a "tax-free" basis. **The Dependent Day Care Account is not eligible for the Employer Contribution.**
4. Sign and date the bottom of the application. Keep the bottom (pink) copy for your records and return the top two copies of the enrollment form to your Coordinator or payroll officer before the deadline date. Shaded areas will be completed by your Coordinator.



YOU MAY QUALIFY FOR AN EMPLOYER CONTRIBUTION

Use the worksheet below to determine if you qualify for an employer contribution to the Health Care Spending Account.

Monthly Employer Contribution for Health Insurance for 2001	1.	\$	234.00
Enter the monthly premium for the health insurance plan you have selected (If you waived coverage, enter -0- on line 2)	2		_____
Subtract line 2 from line 1. This is your eligible monthly employer contribution toward the Health Care Spending Account. *	3		_____
			<small>Divide this number by 2 and enter on line "a" of the enrollment form. Round down if number is uneven.</small>

If line 2 is larger than line 1, you do not qualify for the Employer Contribution, and the difference will be deducted from your paycheck to cover your insurance premium.

REMINDER: The minimum combined (employer and employee) contribution for a Health Flexible Spending Account is \$5.00

If you qualify for an Employer Contribution, you **MUST** complete the enclosed enrollment form in order to participate. **ENROLLMENT IS NOT AUTOMATIC.**

The Commonwealth of Kentucky does not discriminate on the basis of race, color, national origin, sex, religion, age or disability in employment or the provision of services. The information contained in this booklet is available in an accessible format upon request.

AN EQUAL OPPORTUNITY EMPLOYER M/F/D

